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Michigan Long-Term Care Supports and Services Advisory Commission
Meeting of January 25, 2010
Capitol View Building, Lansing, MI

- Agenda, Monday, January 25, 2010
- State Profile Tool Grant Update
- MI Choice Waiver Update
- LTC Provisions in the National Health Care Reform Synopsis

LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

AGENDA

Monday, January 25, 2010
10:00 a.m. – 3:00 p.m.
Capitol View Building, Lansing
1st Floor, MDCH Conference Center

10:00	I.	Call to Order/Roll Call	Chair, RoAnne Chaney
10:05	II.	Commission Changes	
		A) Loss of Commissioner William Gutos	
		B) Recognize Members Whose Terms Expired or Who Have Resigned	
		C) Welcome New Members	
	III.	Review & Approval of November 23, 2009 Draft Minutes	
	IV.	Review & Approval of Agenda	
10:30	V.	Medicaid Long-Term Care Policy Updates	Susan Yontz, MDCH
	VI.	MI Choice Waiver/Nursing Facility Transitions/Money Follows the Person Updates	Michael Daeschlein, MDCH
12:00–1:00		Lunch	
1:00	VII.	Public Comment	RoAnne Chaney
	VIII.	Executive Committee Report	
		A) Executive Committee Membership	
		B) Direction of the Commission	
2:00		Break	
2:10	IX.	LTCSS Provisions in the National Health Care Reform Debate – A Synopsis	Pam McNab, OSA
2:40	X.	Commission Discussion	RoAnne Chaney
		A) Workgroup Updates	
		B) Other Commission Announcements	
		C) March Agenda Items	
		D) Action Items	
3:00	XI.	Adjournment	

Next meeting: March 22, 2010 from 10:00 a.m. – 3:30 p.m., Capitol View Building, 201 Townsend Street, Lansing, MI, 1st floor – MDCH Conference Center.

Update to LTC Supports and Services Advisory Commission

State Profile Tool Grant

The purpose of the grant is to develop a profile of Michigan's publicly-funded LTC system and to assist the Centers for Medicare and Medicaid Services (CMS) in the development of national benchmarks for states to use in assessing their progress toward achieving a balanced, person centered long term supports (LTS) system. A balanced system offers individuals with a reasonable array of options that include adequate choices of both community and institutional options. For purposes of this project, LTS is defined as state funded (primarily Medicaid) supports.

Phase I concluded with the submission of the Profile of Michigan's Publicly-Funded LTC Services in June, 2009. The report is available on-line at:
http://www.michigan.gov/ltc/0,1607,7-148--225858--,00.html

Phase II activities focus on the development of national indicators and data collection. Indicators include:

- Supporting employment opportunities
- Coordination between HCBS and institutional care
- Support for Informal/Unpaid caregivers
- Nurse delegation
- Shared mission/vision statement
- Coordination between LTS and housing
- Availability of options for self determination
- Global budget
- PCA registration
- Health promotion programs
- Streamlined access systems
- Employment rates of persons with disabilities
- Preventative health care visits
- Service coordination

The National Balancing Indicator Contractor (NBIC) is collecting as much utilization information as possible from federal level databases. States are completing self assessment questionnaires to report on policy and practice. Self assessments for the first four indicators listed above were submitted on January 20.

The SPT Stakeholder Advisory Group is meeting on January 29 to begin deliberation of Michigan specific indicators.

Jane Church
1/25/2010

MI Choice Waiver Update

LTC Supports and Services Advisory Commission

January 25, 2010

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Funding

2010 Appropriation: $174,326,800

Includes:

- MI Choice is licensed settings: $14,109,100
- Affordable Assisted Living: $2,555,000
- MFP Grant: $10,094,000

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Enrollment

- Total slots used in 2007: **9,291**
- Total slots used in 2008: **9,925**
- Total slots used in 2009: **10,132**

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MI Choice Waiting List

- 4th Quarter, 2009: 4,890
- 4th Quarter, 2008: 4,200
- Average time on waiting list: 99.8 days

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2009-2010 Initiatives

- MI Choice in licensed settings
- MSHDA-MDCH Affordable Assisted
- Living Project
- MFP Housing Coordinators
- SCORE (Support Coordination and Operations Reimbursement) funding replaced administrative funding formula

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MI Choice in licensed settings

- Implemented July 1, 2009
- 2-5 Residential Services Staff Positions funded at each waiver agent
- Training sessions and teleconferences
- Anecdotal evidence of success

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MSHDA-MDCH Affordable Assisted Living Project

- Heron Manor, Grand Rapids, opened in 2009
- 3 American House properties to be added in 2010
- 4 sites under development

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SCORE
(Support Coordination and Operations Reimbursement)

Factors determining an agency's portion of SCORE funds:

- Size of organization
- Acuity of population served
- Quality performance
- Nursing facility transitions
- Services per participant

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Nursing Facility Transitions

	MI Choice	Other Community	Totals
FY 2005	37	5	42
FY 2006	221	60	281
FY 2007	337	115	452
FY 2008	396	149 – Other 34 – AHH	579
FY 2009	656	147 – Other 76 – AHH	879
FY 2010	250	39 – Other 14 – AHH	303

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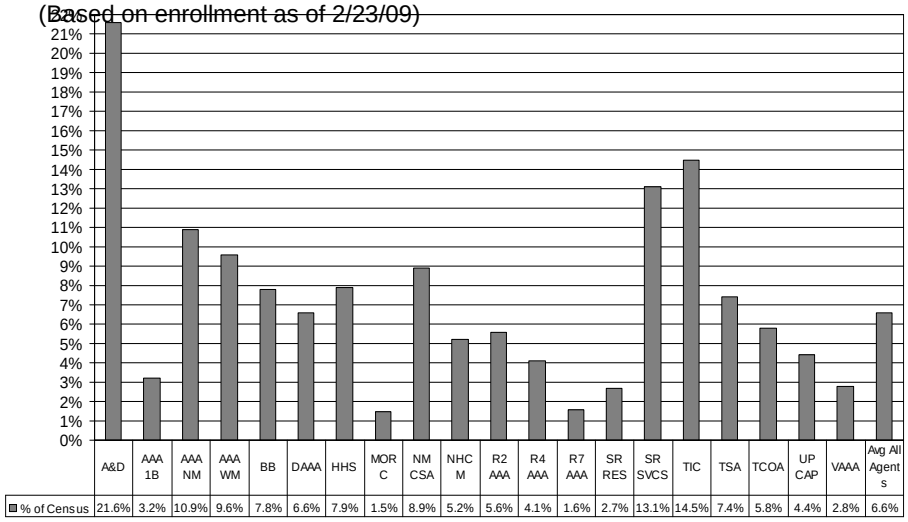
FY 2009 NFTs as a Percent of Census

(Based on enrollment as of 2/23/09)



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Waiver Agent Codes

- A&D – A & D Home Health Care, Inc., Saginaw, MI
- AAA1B – Area Agency on Aging 1B, Southfield, MI
- AAANM – Area Agency on Aging of Northwest Michigan, Traverse City, MI
- AAAWM – Area Agency on Aging of Western MI, Grand Rapids, MI
- BB – Region 3B AAA @ Burnham Brook Center, Battle Creek
- DAAA – Detroit Area Agency on Aging, Detroit, MI
- HHS R8 – Health Options, Grand Rapids, MI
- HHS R14 – Health Options, Grand Rapids, MI
- MORC – Macomb Oakland Regional Center, Clinton Township, MI
- NMCSA – Northeast MI Community Service Agency, Inc., Alpena, MI
- NHCM – Northern Lakes Community Mental Health, Traverse City, MI
- NMRHS – Northern Michigan Regional Health System, Petoskey, MI
- R2 AAA – Region 2 Area Agency on Aging, Brooklyn, MI
- R4 AAA – Region 4 Area Agency on Aging, St. Joseph, MI
- R7 AAA – Region VII Area Agency on Aging, Bay City, MI
- SRRES – Senior Resources, Muskegon Heights, MI
- SRSVCS – Senior Services of Kalamazoo, Kalamazoo, MI
- TIC – The Information Center, Taylor, MI
- TSA – The Senior Alliance (AAA), Wayne, MI
- TCOA – Tri-County Office on Aging, Lansing, MI
- UPCAP – Upper Peninsula Area Agency on Aging, Escanaba, MI
- VAAA – Valley Area Agency on Aging, Flint, MI

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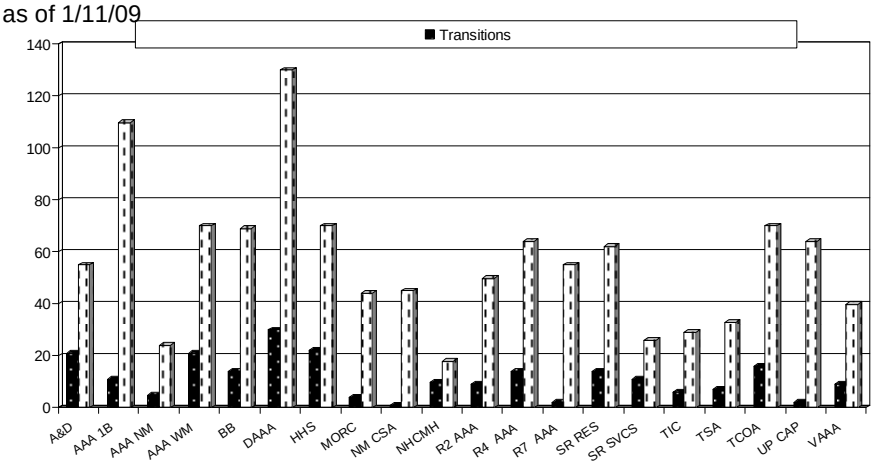
NFT Benchmark for FY 2010

as of 1/11/09



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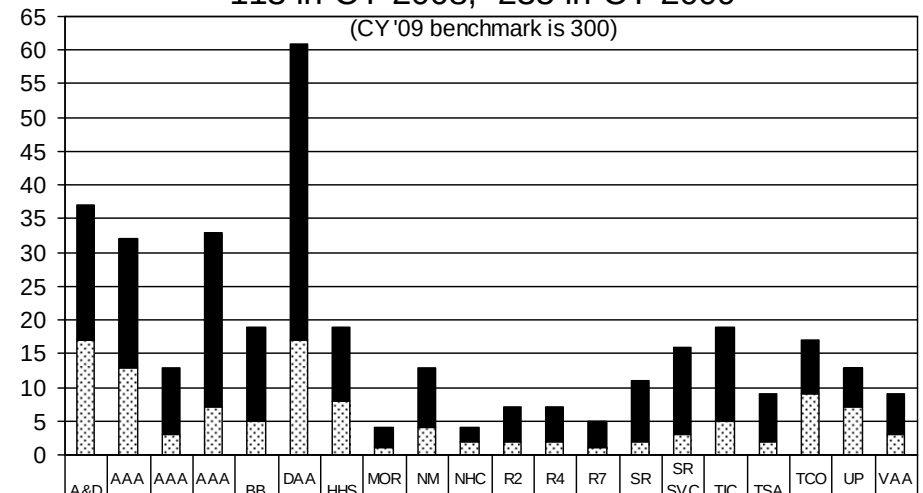
MFP Transitions by Waiver Agent
113 in CY 2008, 235 in CY 2009

(CY '09 benchmark is 300)



	A&D	AAA 1B	AAA NM	AAA WM	BB	DAA A	HHS	MOR C	NM CSA	NHC M	R2 AAA	R4 AAA	R7 AAA	SR RES	SR SVC S	TIC	TSA	TCO A	UP CAP	VAA A
■ 2009	20	19	10	26	14	44	11	3	9	2	5	5	4	9	13	14	7	8	6	6
⊡ 2008	17	13	3	7	5	17	8	1	4	2	2	2	1	2	3	5	2	9	7	13

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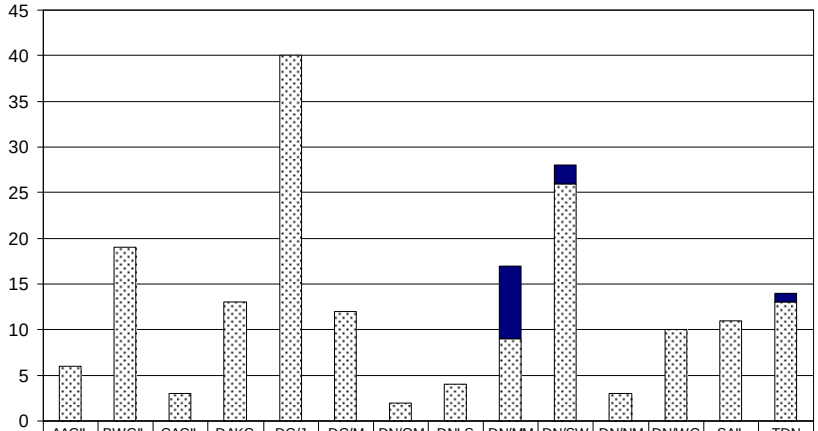
FY '09 Transitions by CILs - 171



	AACIL	BWCIL	CACIL	DAKC	DC/J	DC/M	DN/OM	DNLS	DN/MM	DN/SW	DN/NM	DN/WC	SAIL	TDN
■ Under contract									8	2				1
⊡ Transitioned	6	19	3	13	40	12	2	4	9	26	3	10	11	13

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CIL Codes

- AACIL – Ann Arbor CIL
- BWCIL – Blue Water CIL
- CA – Capital Area CIL, Lansing
- CC – Community Connections
- DAKC – Disability Advocates of Kent County
- DCJ – disABILITY Connections, Jackson
- DC – Disability Connections, Muskegon
- DNOM – Disability Network Oakland & Macomb
- DNLS – Disability Network Lakeshore
- DNMM – Disability Network Mid-Michigan
- DNSW – Disability Network Southwest Michigan
- DNN – Disability Network Northern Michigan
- DNWC – Disability Network Wayne County
- SAIL – Superior Alliance for Independent Living
- TDN – The Disability Network, Flint

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Characteristics of Transitionees

- The average length of stay for 1469 NFTs between 1/1/05 & 12/7/09 was 457 days, with an average of 371 days/episode of MI Choice enrollment
- In 2009, of the 879 transitions & diversions, 393 (45%) were less than the age of 65, and 486 (55%) were aged 65 and better.
- The youngest was 18 (22 were under the age of 30), the oldest was 108 (5 were over the age of 100, 19 were over the age of 90). Average age was 68.5 years.
- Longest time in NF before transition was 11 years.
- 655 (75%) enrolled in MI Choice, 80 (9%) enrolled in Adult Home Help, and the other 16% may have received other community services or perhaps no services.

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Contact information:

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Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
	1. Overall Approach to Expanding Access to Health Care Coverage:		
Access Rec. #8, Strategy # 9, Expand LTC employee access to affordable health care	• Require most U.S. citizens & legal residents to have health insurance • Create state-based exchanges: individuals purchase coverage with premium & cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level • Create separate exchanges where small businesses purchase coverage • **Expand Medicaid to 133%** of the federal poverty level	• Same as Senate • Create a health insurance exchange: individuals & smaller employers purchase health coverage, with premium & cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level • Require employers to provide coverage to employees or pay into an exchange Trust Fund, some exceptions for certain small employers & offset costs for providing • **Expand Medicaid to 150%** of the poverty level	Poverty level=$18,310 family of 3 in '09 ● Senate State-based exchanges give States > control over coverage (Kaiser) ● US can't afford HCR b/c of economy ● US can't afford not to do HCR b/c of same **● Everyone has an idea about HCR, some political will, limited political agreement**
	2. Bolster Support Services Delivered at Home & in Community		
Finance Rec #9, Strategy #6 &7 – Increase # of people who have LTC insurance Increase number of people provided with LTC services, decrease MI Choice Wait	• **Long-term Care: CLASS Act establishes a new public national LTC insurance program for purchasing community living assistance services & supports**. • Financed by voluntary payroll deductions for all working adults >=18 years. • Automatic enrollment with an op-out option, alternate payment methods available • Five-year vesting period. • Enrollees eligible for benefits who meet specific functional &/or cognitive impairment expected to last >=90 days, & certified by licensed health care practitioner. • A cash benefit is paid based on functional ability, averaging not less than $50/day with no lifetime or aggregate limit • Requires HHS Secretary to set premiums to ensure solvency for 75 yrs	• **Establishes a national, voluntary insurance program for purchasing community living assistance services and supports** (CLASS). • Same as Senate. • Same as Senate • Same as Senate • Same as Senate. ● Same as Senate. ● Same as Senate ● Same as Senate ● Same as Senate ● Non working, non-institutionalized spouses of employed worker could enroll	**Consumer Endorsed Service Preference** ● proposed in both the Senate & House, creates a **new national voluntary LTC insurance program** that provides coverage for a host of HCBS services to enrollees who have paid premiums for at least 5 yrs. (NSCLS)

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
List	• MA enrollees in institutions retain 5% of their cash benefit • MA enrollees receiving HCBS or PACE retain 50% of their cash benefit • Premium subsidies available for eligible people aged 18-22 who are full time students while working OR for workers with income below poverty • Self-employed individuals could enroll • Class program treated same as qualified LTC insurance policy • No taxpayer funds (fed funds from any source other than Class premiums) will be used to pay benefits	● Amends Internal Revenue Code so CLASS plan premiums & benefits are treated like those for qualified LTC insurance policies ● States comply with MA primary & secondary payor rule for CLASS program ● States designate/create fiscal agents for personal care attendant workers serving CLASS beneficiaries	
Rec #4 Expand Range of LTC Service Options Rec #2 Strategy #3 amend & fund MI Choice to serve all eligible clients	**Establish Community First Choice Option in Medicaid to provide community-based attendant supports & services to individuals with disabilities who require an institutional level of care.** (Effective October 1, 2010) ● Provides 6 % point increased FMAP to States choosing this option, ends after 5 yrs ● States authorized to provide community transition supports & services (e.g., rent/utility deposits, first month's rent & utilities, bedding, basic kitchen supplies) to institutionalized individuals who meet the eligibility criteria.	Expresses the Sense of Congress that states should be allowed to elect under the MA state plans to implement a Community First Choice Option for community-based attendant services & supports furnished in the home and community are available to MA beneficiaries who would otherwise qualify for institutional care & that federal match for State Medicaid dollars will be enhanced (Manager's amendment – non binding statement)	**Consumer Endorsed Service Preference** ● Offers choice between NF or HCBS attendant services, includes NF transition services. **Makes HCBS an entitlement, rather than an optional benefit.** Ideally, this would be a mandatory MA benefit that would not have an income limit (NSCLS)
Rec #4 Expand Range of LTC Service Options Rec #3 & #4 Establish SPEs & flexible service options	**Removal of Barriers to Providing HCBS:** Amends Section 1915(i) of the Social Security Act to remove barriers to providing HCBS by giving States the option to provide more types of HCBS through a State Plan (SP) amendment to individuals with higher levels of need, rather than through waivers ● Requires states to provide the state plan (SP) benefit "statewide" ● Prohibits state from setting caps on the # of individuals who receive coverage ● Enables states to target benefits to people with selected conditions as states choose ● Individuals receiving coverage under the SP, grandfathered into	● No similar provision	**Changes proposed by the Senate make the HCBS State Plan Benefit a better service for recipients.** (NSCLS) ● Mandating statewide application of the benefit & protecting recipients of the benefit against termination when States modify the clinical criteria are valuable changes. (NSCLS) ● **Bill passed by House contains**

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
	services if the criteria for eligibility are modified for as long as condition meets previous criteria. Amended to create new financial incentives for States to shift MA beneficiaries out of NFs into HCBS ● Eligible States spend < 50% total expenditures for LTCC services on HCBS ● HHS Secretary may determine among States that apply & qualify which will participate ● Qualifying States with < 25% of LTCC expenditures for HCBS will receive a 5% point increase in FMAP; States with 25-50% will receive a 2% point increase ● States may increase the income eligibility for HCBS as part of this provision ● Requires qualifying States to establish a statewide "No wrong door – SPE system to enable consumer access to Long Term Care Services & Support (LTCSS) ● Requires qualifying States to develop CM services to assist beneficiaries and family caregivers in service planning & transitioning from institutional to HCBS services ●Allocates up to $3 Billion for Medicaid HCBS		**few provisions that affect MA's LTC coverage, but bill passed by the Senate contained several provisions that would significantly improve MA options for those with chronic needs (NSCLS)** ● Michigan is an eligible State to receive enhanced financial incentives as we spend less than 50% of total expenditures for LTC Services & Supports on Home & Community Based Services (HCBS) ● Michigan's developing 2009 ADRC Partnership Grant using "No Wrong Door" model ☺ Yeah! $3 Billion for HCBS
Access LTC Task Force Rec. #2. Improve access by MFP,	**Extends the Medicaid Money Follows the Person (MFP) Rebalancing Demonstration funded by DRA through September 2016 from 2011** • Modifies eligibility rules: originally required that individuals reside in institution for not less than 6 months, reduced to requiring that individuals reside in institutions for not < 90 consecutive days. • Any days an individual spends in an institution receiving short-term rehab services will "not be taken into account for purposes of determining the 90-day period".	• No similar provision.	☼ Yeah! 5 more yrs of NF transition ●**MFP is a valuable component** of the effort to "balance" Medicaid's LTC spending, important incentive to States, **increases possibility for many institutionalized individuals to return home or to other community** option. (NSCLC)
	Protection for Recipients of HCBS Against Spousal Impoverishment:	● No similar provision.	**New for State Plan benefit**

Long Term Care Provisions in the National Health Care Reform Synopsis

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	● Requires States to **apply spousal impoverishment rules to beneficiaries who receive HCBS waiver & the community-based attendant services** ● Applies to a 5 year period beginning 1/1/2014		**services**
Establish SPEs	Funding to Expand State Aging & Disability Resource Centers (ADRCs) ● Appropriates $10 Million annually between FYs 2010 – 2014 to carry out ADRC initiatives provided in the Older American's Act	● No similar provision	**ADRC is a valuable AoA initative that is worthy of additional support** provided in this bill. (NSCLS)
Expresses the sense of the MA TF	**Expresses the Sense of the Senate that during the 111th Congress, Congress should address LTCSS in a comprehensive way that guarantees elderly & people with disabilities the care they need, in the community, as well as in institutions.**	● No similar provision	Good sense **We can't afford not to include LTC in HCR**
Convene broad based coalition (#4)	**3. Improve Coordination of Health Care & Support Services. Building Infrastructure for Program & Policy Development**		
	Medicaid (MA) & Childeren's Health Insurance Program (CHIP) Payment & Access Commission (MACPAC) Clarifies the topics to be reviewed by the Medicaid & CHIP Payment & Access Commission (MACPAC) including: ● MA & CHIP enrollment & retention processes, coverage policies, quality of care, how interactions of policies between Medicare & Medicaid affect access to services, payments & dually-eligible individuals & additional reports of State specific data ● Authorizes $11 Million to fund MACPAC for FY 2010	● Authorizes $11.8 Million for the MA and CHIP Payment & Access Commission ● Directs the Commission to study, among other topics, State MA payment policies for NFs	
Rec #9 Financing, Strategy 3b, p. 23 – Michigan Congressional Delegation should strongly	**Improved Coordination & Protection for Dual Eligibles -** HHS Secretary must **establish a Federal Coordinated Health Care Office** (CHCO) within CMS by 3/1/2010 to bring together Medicare (MC) & Medicaid (MA) program officials to: ● **More effectively integrate benefits for both MC & MA programs** ● Improve coordination between Federal & State governments for	CMS must establish a dedicated office or program to improved coordination of benefits & other policies for MC & MA dually eligible beneficiaries ● HHS Secretary must review MC & MA policies & identify areas where better coordination & protection could improve care, lower costs & issue improving coordination & protection guidance to States	**Senate & House both see need to coordinate, integrate, & eliminate conflicts between the MC & MA programs to improve the quality of service delivery for dual eligibles**

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
advocate that the federal government assume full responsibility for health care needs of individuals who are dually eligible for MC & MA Rec #4, Strategy 1 Ensure the availability of the health & LTC services & supports	individuals eligible for benefits under both MC & MA programs (dual eligibles), ensure duals have full access to items & services they are entitled The goals of the CHCO are: ● Provide full access to MC & MA benefits that dual eligibles are entitled ● Simplify the access to services process for dual eligibles ● Increase dual eligibles understanding of & satisfaction with coverage ● Eliminate regulatory conflicts between MC & MA ● Improve care continuity for dual eligibles ● Eliminate cost shifting between MC & MA & among related Health Care providers ● Improve MC & MA provider performance & quality of service delivery Specific responsibilities include: ● Provide States, Special Needs Plans (SNPs) & providers with education & tools to align MC & MA benefits ● Support State efforts to coordinate & align acute & LTC service for duals ● Provide support for coordination contracting & oversight by States & CMS with integrating MC & MA ● Consult & coordinate with MedPAC & NACPAC re: relevant policies ● Study the drug coverage provision for new full-benefit dual eligibles, & monitor & report total annual expenditures, outcomes & access to benefits ● Submit annual report to Congress with recommendations for legislation to improve care coordination & benefits for duals	● Simplify duals' access to benefits & services ● Improve continuity of care for duals ● Reconcile regulatory conflicts between MC & MA for duals ● Improve quality performance & decrease total cost under MC & MA for duals ● Specific responsibilities include: ● Examine MC & MA payment systems to develop strategies that foster more integrated & higher quality care ● Develop methods to facilitate access to post-acute & HCBS & identify activities that could lead to better coordination of HCBS ● Study how best to efficiently & effectively reach & enroll dual eligibles ● Assess communication strategies to determine best materials & outreach ● Research & evaluate areas where service utilization, quality & access to cost sharing protection can be improved & assess enrollee service delivery satisfaction factors ● Create & make publicly available a database describing eligibility, benefits & cost sharing assistance available to duals by State ● Provide support for coordination of Federal & State contracting ● Provide technical assistance to State MA agencies for coordination initiatives designed to improve acute & LTC for dual eligibles ● Monitor program cost for duals, make recommendations for optimizing quality & cost performance across MC & MA ● Coordinate activities related to MC Advantage plans under MA	
	Establish a MC/MA CMS Innovation Center for MC & MA Services	• Same as Senate	Senate & House agreement

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
	The purpose is to research, develop, test & expand **innovative payment & delivery arrangements** to improve the quality & reduce cost of care provided to participants in each program. ● Dedicated funding to test models require benefits not now MC covered ● Successful models can be expanded for both programs		
Rec #5, Strategy 9 Identify & promote use of elements of established models for chronic care management & coordination	**Demonstration Programs & New Delivery Models, Accountable Care Orgs** Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs & quality of care received by their participant panel over time ● ACOs can include groups of health care providers (physician groups, hospitals, nurse practitioners & physician assistants & others) ● ACOs that meet quality of care targets & reduce cost of participant care relative to a spending benchmark are rewarded with a share of the MC savings achieved Amended to afford HHS Secretary flexibility to consider a partial capitation model (when ACO is at financial risk for some, but not all, services) OR other payment models, including private pay	Creates an alternative payment model within MC fee-for-service to reward physician-led organizations that take responsibility for the costs & quality of care received by their participant panel over time ● ACOs can include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations ● ACOs can include nurse practitioners, PAs & others designated by the ACO ● ACOs that reduce participant costs relative to spending benchmarks & meeting quality targets are rewarded with a share of program savings ● CMS may allow ACOs to continue operating as long as they are reducing costs while maintaining quality or improving quality ● HHS Secretary must establish a program that allows State MA programs to pilot one or more models used in MC ACO pilot established by section 1301 of the bill. Administrative costs matched 90% in the first 2 yrs, 75% in last 3 yrs	Senate & House general agreement
Rec #5, Strat #9	**Medical Homes:** Senate has proposal	House has proposal	**Pays medical homes for chronic care services**
	Independence at Home Demonstration Program	Creates demonstration for chronically ill MC beneficiaries	Same provision for both Senate & House
	Implementation of Med Management Services in Treatment of Chronic Disease	Medication therapy management provided by licensed pharmacist – new program	Same provision for both Senate & House
Rec #5, Strat	● **No similar provision**	**Community Based Collaborative Care Networks** Establishes new	**Establishes new collaborations**

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	**Comment**
#1 Convene broad based coalition aging, disability & other orgs		program to support community based collaborative care networks, a consortium of health care providers offering coordinated & integrated health care services for low-income populations or medically underserved communities. Authorizes sums as may be necessary each year, FY 2011-FY 2015, to carry out program	**across health care organizations**
	● **Community Base Care Transitions Program –** Provides funding to **hospitals** & community based entities that furnish evidence base care **transition services** to MC beneficiaries at high risk for readmission	● **No similar provision**	**New transition services can be provided by hospitals** & HCBS orgs
	Medicare Hospice Concurrent Demonstration Program – HHS Secretary establishes a 3 yr demo program to allow **participants eligible for hospice care to also receive all other MC covered services** during same time period. Demo is conducted in up to15 rural & urban hospice programs. Evaluates impacts of the demonstration on participant care, Quality of Life & MC program spending	● **No similar provision**	
	Patient Navigator Program, coordinate health services, provider referrals, outreach	● No similar provision	**Helps people with health service barriers**
	Payment Reform, Bundling, reform payment for post acute care MC services	Improve patient care & achieve savings for MC through bundled payment model	MC payment reform
	Extension of Special Needs Plan (SNP) Program, Extends SNP program through 2014 & requires SNPs to be NCQA approved ● HHS can apply a frailty payment adjustment to fully integrated dual eligible SNPs that enroll frail populations ● Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service MC who are enrolled in SNPs that do not meet statutory target definitions & requires dual-eligible SNPs to contract with State MA programs beginning 2013 ● Requires an evaluation of MC Advantage risk adjustment for chronically ill pops	● Extends SNP through 2013 ● Extend fully integrated dual eligible SNPs that participated in certain demonstration projects & have a contract with their State MA agency through 2016 ● Extends the moratorium on service area expansions for dual eligible SNPs that do not meet certain requirements	Senate & House both **extend SNP program**
	Medicare Senior Housing Plans, allows demo plans that serve	● **Same as Senate**	Senate & House agree

Long Term Care Provisions in the National Health Care Reform Synopsis

LTC Taskforce	**Senate Bill -** Patient Protection and Affordable Care Act (HR 3590)	**House Bill –** Affordable Health Care for America Act (H.R. 3962)	Comment
	residents in continuing care retirement communities to operate under MC Advantage program.		
	● **No similar provision**	**New Benefits Supporting Care Coordination, Dismantling Advance Care Planning Info,** Requires health insurers in the Exchange to present enrollees with resource info available for advanced care planning, voluntary to the individual	
	● **No similar provision**	**Voluntary Advance Care Planning Consultation –** Offers coverage for optional consultation between enrollees & practitioners to discuss orders for life sustaining treatment & other options for advance care planning	
Rec#5, Strategy 4 Develop & support programs to address prevention, chronic care & caregiver support	**Annual Wellness Visit MC Coverage,** Provides MC coverage, with no co-payment or deductible, for an annual wellness visit & personalized prevention plan services. ● Services include a comprehensive health risk assessment ● A personalized prevention plan takes into account health risk assessment findings & includes: a 5-10 yr screening schedule; a list of identified risk factors & conditions & strategy to address them; & health advice & referral to education & prevention counseling or community based interventions to address modifiable risk factors, e.g., physical activity, smoking & nutrition.	• **No similar provision**	**Prevention & wellness** program offered by Senate
	4. Improve Medicare Part D Access & Reduce Medication Cost Burden **Reduction/Elimination of the Coverage Gap in MC Part D –** Increases initial coverage limit in the standard Part D benefit by $500 for 2010, thus decreasing the time that a Part D enrollee is in the coverage gap, applies only to 2010. Initial coverage limit for subsequent years separately determined.	● **Eliminates the Part D "doughnut hole**" beginning with a $500 reduction in 2010, complete phasing out this coverage gap by 2019. ● Pays for elimination of the gap with funds raised by requiring drug manufacturers to provide MA rebates for drugs used by full dual eligibles & low income subsidy recipients.	Extremely important to eliminate "donut hole" in Part D Reduces time Part D enrollee is in coverage gap, **saves some Part D enrollees $s currently spent on drug costs**
	MC Coverage Gap Discount Program, Requires 50% discount to Part D recipients	● **Discount for brand-name drugs & biologics purchased during coverage gap**	Senate & House agreement
	No Mid-Year Formulary Changes Permitted, prevents Part D formulary change	● No similar provision	No cost sharing ↑ or reduced coverage

Long Term Care Provisions in the National Health Care Reform Synopsis

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	Negotiation of Lower Covered Part D Drug Prices, HHS Secretary negotiates over drugs $	● No similar provision	Potential for lower drug prices
	Improved Assistance to Low-Income Subsidy (LIS) Beneficiaries, Improve access to Part D	●↑ asset test for Part D eligibles for low income subsidy & MC savings programs	
	Elimination of Part D Cost-sharing for Selected Non-Institutionalized Dual Eligible Individuals, for people receiving HCBS waiver requiring NF LOC	● Same Provision	Senate & House agreement
	5. Enhancing and Revitalizing the Health and Support Services Workforce:		
Work Force Rec. #8, Strategy #5 & #10, Develop health professional curricula and reform current practice…	● No similar provision	Promote Direct Care Workforce/Family Caregiver Support, Amends OAAct: ● Establish Personal Care Attendant Workforce Advisory Panel to examine & promulgate recommendations on working conditions, training/other workforce issues for workers providing LTC supports & services, HH aides, CNAs & PC attendants ● Establishes core competencies for PC attendants ● Establishes a 3-yr demo in 4 states to evaluate the effectiveness of PC attendant core competencies, training curriculum & methods recommended by Panel ● Increases authorization for the Family Caregiver Support Program to $260 M from FY 2011-FY 2013	● Advancement
Rec # , Strategy #8 Improve and increase training for Professionals	**Demonstration Project to Address Health Professions Needs** ● Establish demonstration program to **offer low income individuals opportunity to obtain training/education for health care field occupations expected to experience labor shortages OR be in high demand** ● Demonstrations in up to 6 States for no less than 3 yrs through competitive grants to develop core competencies, pilot training curricula & develop personal & home care aide certification programs ● $85 Million appropriation for 5 yrs (FY 2010-2014), with no more than $5M/yr (FY 2010 -2012) allocated for personal & home care aide	● No similar provision	● **Addresses projected shortages of nurses & retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment & retention grants, & creating a career ladder to nursing**. ♫ $85 Million in workforce

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	demonstration.		training funds♫
Work force, Rec. # 8 Strategy # 5 & #10, direct care workers	**Training Opportunities for Direct Care Workers: Establishes grants to eligible entities to provide advanced training opportunities for direct care workers employed in LTC settings (NFs, ALs, intermediate care facilities & HBCS)** ● Tuition or fee support funds to be allocated ● Participating individuals agree to work in the fields of geriatrics, disability services, LTC or chronic care management for at least 2 yrs following training ● Authorizes $10 Million from FY 2011-2013 for these grants	● No similar provision	● **will increase workforce supply & support training of health professionals** by providing scholarships & loans; supporting primary care training & capacity building **$10 Million in training grants**
	Authorizes Physician Assistants (PAs) to order skilled NF care (eff 1/1/11)	**Expands MC PA's Role**: Allows physician assistants to order skilled NF care. Establishes PAs as eligible providers for hospice care. (Eff 1/1/10)	New – **allows PA to order skilled NF care**
	Payment Incentive for Selected Primary Care Services: **Increase Medicare payment rate by 10% to primary care practitioners for primary care services** ● Primary care practitioners are those with a family, internal, geriatric or pediatric medicine & for whom primary care services are at least 60% of allowed charges (eff 2011-2016)	Increase MC payment rate by 5% to physicians specializing in primary care ● Physicians specializing in primary care are defined both by specialty (e.g., family practitioners, internists, geriatrics & others) & by share of a practice in primary care (at least 50% of allowed charges are for primary care services) ● Eligible health professionals practicing in shortage areas receive additional 5%	**Increase MC payments to primary care practitioners**
Rec. #8, Strategy #10 – curricula that meets needs of consumers	● No similar provision	**Training in Geriatrics & other primary Care Specialties** ● Provides funding to support primary care training & to build academic capacity in primary care, includes family, general internal, general pediatrics medicine OR geriatric training programs.	
Workforce Rec. #8, Strategy #10 – curricula that meets needs of	**Geriatric Ed & Training: Career Awards; Comprehensive Geriatric Education** Authorizes $10.8 Million for geriatric education centers to support training in geriatrics, chronic care management, & LTC for faculty in health professions schools, direct care workers & family caregivers	● No Similar Provision	

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consumers	FY 2011 t0 FY 2014 ● Funds allocated to **develop curricula & best practices in geriatrics** focusing on mental health, medications safety & communication skills in dementia care ● Funds also **expand geriatric career awards to advanced practice** nurses, clinical social workers, pharmacists & psychologists; create a parallel geriatrics career incentive award programs for Master's level candidates: & establish traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing		
Work Force, Rec. #8, Strategy #11, track employment trends	**Health Workforce Evaluation & Assessment** ● **Establishes a national commission to review health care workforce & projected workforce needs.** Goal is to provide comprehensive, unbiased information to Congress & the Administration on how to align Federal health care workforce resources with national needs. Congress to use info when providing appropriations to discretionary programs OR restructuring other Federal funding sources ● Codifies existing national center & establishes several regional centers for health workforce analysis to collect, analyze & report data related to Title VII of the Public Health Service Act primary care workforce programs. The centers to coordinate with State & local agencies collecting labor & workforce statistical information & coordinate/provide analyses & reports on Title VII to the Commission.	Creates an Advisory Committee on Health Workforce Evaluation & Assessment to assess the adequacy & appropriateness of the nation's health workforce, & to make recommendations to the HHS Secretary on federal workforce policies to ensure that the workforce is meeting the nation's needs ● Require HHS Secretary to collect data on the supply, diversity & geographic distribution of the Nation's health workforce, including individuals participating in various federal workforce programs.	● **Evaluates the nation's workforce** ● **Collect workforce data** ● Senate committee assessment goes to Congress ● House committee assessment goes to HHS Secretary
Rec 7- Establish a new QM system	**6. Strengthening Quality& Consumer Protections: Improving Transparency of Information**		
	Requires MC & MA NFs to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so enrollees can compare the facilities	● Same as Senate	Senate & House agreement
7.5 estab	**Requires SNFs & NFs to operate compliance & ethics programs**	● Same as Senate	Senate & House agreement

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broader accountability	36 months after enactment. Directs HHS Secretary to develop a SNFs & NF QA & improvement program by 12/31/11		
7.5 estab broader accountability across LTC array of SS	HHS Secretary required to publish the following information on the **NH Compare MC website:** standardized staffing data, links to State internet websites regarding State survey & certification programs, the model standardized complaint form, a summary of substantial complaints, & # of adjudicated instances of criminal violations by a facility or its employees.	● Same as Senate	**NH Compare** Senate & House agreement
	● Requires SNFs to separately report expenditures for direct care staffing services, indirect care services, capital assets & administrative costs on cost reports. ● Requires HHS Secretary to redesign SNF cost reports to meet the needs of this section within 1 yr. Effective on or after two years after redesign of cost report	● Same as Senate	Reporting of SNF expenditures Senate & House agreement
Rec #3, Strategy #17 Develop grievance & appeals processes	● Requires HHS Secretary to develop a standardized complaint form for use by residents or a person acting on a resident's behalf in filing complaints with a State survey & certification agency & a State LTC Ombudsman program. ● States also required to establish complaint resolution processes	● Requires HHS Secretary to develop a standardized complaint form for use by residents, a person acting on a resident's behalf & **any person who works at a SNF or is a representative of such a worker infiling complaints** with a State survey & certification agency & State LTC Ombudsman Program. ● States also required to establish complaint resolution processes.	Senate & House basically agree, House addition of employee of SNF or their rep
7.5 establish broader accountability	Requires HHS Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data & to take into account services provided by any agency or contract staff	● Same as Senate	Senate & House agreement
7.5 establish broader accountability	Requires the Government Accountability Office to conduct a **study** on the **Five-Star Quality Rating System** that includes an analysis of systems implementation & any potential improvements to the system	● No Similar Provision	**Senate wants to study Five Star Rating System**
	Establishes a national program for LTC facilities & providers to conduct screening & **criminal** & other **background checks** on prospective direct access employees	● Same as Senate	Senate & House agreement
	Permits HHS Secretary to require SNFs & NFs to **conduct dementia management & abuse prevention training** in pre-employment	● Same as Senate	**NF training requirement Senate & House agreement**

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	training programs		
Rec #1, Strategy # 2 reflect a commitment to organizational culture change, competency & sensitivity	● No Similar Provision	HHS Secretary must conduct 2 facility based demonstration projects to develop best practice models: ● To identify facilities best practices involved in the "culture change" movement, including development of resources NFs may be able to access information in order to implement culture change ● To identify best practices in information technology that facilities are using to improve resident care	**House included PCP culture change**
	Other Quality Provisions: Elder Justice ● No Similar Provision	Establishes advisory capacity & grants to further elder justice providing the following: An Elder Justice Coordinating Council within the Office of the Secretary that will make recommendations to the Secretary	
	7. Waste, Fraud, and Abuse:		
Rec. # 9-Adopt financing structures that maximize resources, promote consumer incentives & decrease fraud	• **Reduce waste, fraud, & abuse in public programs** with provider screening • Enhanced oversight periods for new providers/suppliers & enrollment moratoria in areas identified as being at elevated risk of fraud • Requires MC & MA program providers & suppliers to establish compliance programs • **Develop a database to capture & share data across federal & state programs**, increase penalties for submitting false claims & increase funding for anti-fraud activities	• **Reduce waste, fraud, and abuse in public programs** by allowing provider screening, enhanced oversight periods & enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs & by requiring MC & MA program providers/suppliers to establish compliance programs.	**Senate proposes sharing data across Federal and State programs**

Note: The House & Senate comparison is primarily based on the January 2010 SCAN Foundation Policy Brief #1 unless otherwise referenced as the National Senior Citizens Law Center (NSCLC) or the Kaiser Foundation

One of the authors of SCAN brief includes: Lisa Shugarman, Ph.D., University of Michigan, previous student of Brant Fries Ph.D., worked with MDCH conducting evaluation & research on LTC issues.